COLORADO INDIGENT CARE PROGRAM

FISCAL YEAR 2014-15

MANUAL

SECTION IX:

MISCELLANEOUS MATERIAL

EFFECTIVE: JULY 1, 2014

Colorado Indigent Care Program
Client Authorization
For the Use and Disclosure of Protected Health Information

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 states that we cannot share your protected health information without your permission, except in certain situations. For example, your protected health information can be shared without your permission if it is used to facilitate your health care treatment, payment, to determine enrollment or eligibility for benefits, or for health plan operations. If you sign this form, you are giving us permission to share the protected health information you indicate below. This does not protect the information from being shared with more people once it leaves our office.

This authorization will only last until the date you specify, and must expire on a specific date or upon the occurrence of a specific event.

If you decide later that you do not want us to share your protected health information any more, you may cancel your authorization at any time by signing the REVOCATION SECTION at the end of this form and returning it to Colorado Department of Health Care Policy and Financing, Special Financing Division. Any revocation can only apply to future disclosures or actions regarding your protected health information and cannot cancel actions taken or disclosures made while the authorization was in effect. See the Department's Privacy Policies and Procedures on *Use and Disclosure of Protected Health Information – Authorization Required,* pursuant to 45 C.F.R. 164.508.

Date: _____

I, _____ (print your name) **authorize the following person or group to disclose my protected health information with the Colorado Department of Health Care Policy and Financing:**

_____

_____

_____

The following information may be disclosed:

- ❑ Information related to eligibility for benefits for the following time period (specify dates):

  From: _____ To: _____

- ❑ Information including claims, reports and other documents related to claims for benefits from a certain time period (specify dates):

  From _____ To _____

- ❑ Information relating to payment or lack of payment of benefits for services rendered on a specific date:

  Date: _____ Name of health care provider: _____

❑ Other (specify): _____

Purpose of request for information: (If you prefer not to state a purpose, please state "At the request of the individual")

_____

Expiration of authorization: (You must specify a date or event, i.e., at the end of litigation)

Date / event of expiration: _____

Covered entities under HIPAA may not condition treatment, payment, enrollment or eligibility for health plan benefits on receipt of an authorization.

Name: _____ Signature: _____

Date of birth: _____ Social Security: _____

Name of Designated Personal Representative: _____
*** Legal documentation must be included to show authority to receive information ***

Signature of Designated Personal Representative: _____

Relationship of Designated Personal Representative: _____

This form must be received by the Department's Colorado Indigent Care Program prior to any discussion with a third party (i.e. hospital, clinic or billing agent) a client's eligibility for benefits; information including claims, reports, and other documents related to claims for benefits; or information relating to payment or lack of payment of benefits for services rendered. Without this form, the Colorado Indigent Care Program will not discuss any client specific issues with any provider or outside agent.

Fax 303-866-4411
Attention: Colorado Indigent Care Program
1570 Grant Street
Denver, CO 80203-1818

REVOCATION SECTION

I understand that I have the right to revoke this authorization at any time. I understand that the revocation is only effective after it is received. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.

I no longer want my protected health information used or disclosed.

Signature: _____ Date: _____

COLORADO INDIGENT CARE PROGRAM (CICP)
THIS IS NOT HEALTH INSURANCE

Name ______________________________

Rate Assigned ________ Copay Cap $__________

County Code______ ______________

App Date __________ Expires __________

Health Care Facility______________________

Technician's Signature Phone

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Health Care Facility______________________

Technician's Signature Phone

The following family members are covered under
the rating assigned on the front of this card
(family members eligible for Medicaid or CHP+ are not listed)

Name: _____ DOB_____
Name: _____ DOB_____
Name: _____ DOB_____
Name: _____ DOB_____
Name: _____ DOB_____
Name: _____ DOB_____

Please present this card each time you receive services at a CICP Provider.

Rev. 7/14

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